MBCHP Visit Form – Part 1 of 2

Site Name: _____

Provider Name: _____

- Please send **Part 1** immediately following the office visit and send **Part 2** when test results are available.
- Be sure to use a new **Part 1** Visit Form every time the client returns for a Routine Screening or Short Term Follow-Up Office Visit

Name:_____ **DOB:** __ __ / __ __ / __ __ __ __ **SSN** or **"A" Number:** _____
(Last Name, First Name, Middle Initial)

Date of this visit: ___ ___ / ___ ___ / ___ ___ ___ ___ Please check one: ❑ Routine screening visit ❑ Short-term follow-up visit

Is the client reporting any breast symptoms? ❑**Yes*** ❑No

***If yes, type of symptom**_____

CLINICAL BREAST EXAM (CBE)

Clinical Breast Exam (CBE) **not** performed at this visit – reason:

- ❑ Unable due to clinical/medical reason (CBE due date: __ __ / __ __ / __ __ __ __)
- ❑ Patient refused
- ❑ Discussed but not needed this visit (CBE due date: __ __ / __ __ / __ __ __ __)

CBE Results: ❑ Negative Findings
❑ Benign Findings (such as fibrocystic changes, diffuse lumpiness or nodularity)
❑ Discrete Palpable Mass <u>not suspicious for cancer</u> (i.e., previously worked-up or determined benign)
****Abnormal Exam:**
❑ Nipple or Areola abnormalities
❑ Skin Dimpling or Retraction
❑ Discrete Palpable Mass <u>suspicious for cancer</u>
(i.e., cystic or solid masses that have not been evaluated beyond mammography)

Plan: ❑ Next routine screening due __ __ / __ __ / __ __ __ __
❑ Short-Term Follow-Up is recommended and will be due __ __ / __ __ / __ __ __ __
****Immediate consultation/diagnostic testing is required:** **Diagnostic Provider:** _____

Appointment Date: ___ ___/ ___ ___/ ___ ___ ___ ___

MAMMOGRAM SCHEDULING

❑ Mammogram not ordered at this visit

Mammogram scheduled: Mammography facility: _____

Date of Mammogram**: ___ ___ / ___ ___/ ___ ___ ___ ___**

PELVIC EXAM

❑ Pelvic Exam not performed this visit

If applicable, please select one: ❑ Patient has complete hysterectomy for benign condition (cervix absent)
❑ Patient had supracervical hysterectomy for benign condition (cervix present)
❑ Patient had hysterectomy for cervical neoplasia (cancer)

Pelvic Exam Results: ❑ Cervix normal on exam, next routine screening due __ __ / __ __ / __ __ __ __
❑ Cervical abnormality detected, <u>not suspicious for cancer</u>
****Abnormal Exam:**
❑ Cervical abnormality detected, <u>suspicious for cancer</u>

****Immediate consultation/diagnostic testing is required:** **Diagnostic Provider:** _____

Appointment Date: ___ ___/ ___ ___/ ___ ___ ___ ___

PAP TEST

❑ Pap test not performed this visit

Specimen Type
❑ Conventional smear
❑ Liquid based
❑ Other

MBCHP Visit Form – Part 2 of 2

Site Name: _____

Provider Name: _____

- Please send **Part 2** immediately after test results have been received.
- If results are pending at this time, please update this form with additional information when received and resubmit it to the MBCHP.

Name:_____ **DOB:** __ __ / __ __ / __ __ __ __ **SSN** or **"A" Number:** _____
(Last Name, First Name, Middle Initial)

Date of this visit: ___ ___ / ___ ___ / ___ ___ ___ ___

Date of test: ___ ___ / ___ ___/ ___ ___ ___ ___
Please check one: ❑ Routine screening
❑ Short-term follow-up test

PAP TEST RESULTS

Cytology Laboratory: _____

Specimen Type ❑ Conventional smear
❑ Liquid based
❑ Other

Specimen Adequacy ❑ Satisfactory
❑ Satisfactory but limited
❑ Unsatisfactory

Results Reported in Bethesda 2001:
❑ Negative for intraepithelial lesion or malignancy
❑ Atypical squamous cells of undetermined significance (ASC-US)
❑ Low grade SIL (including HPV changes)
❑ ****Atypical squamous cells cannot exclude HSIL (ASC-H)**
❑ ****High grade SIL**
❑ ****Squamous Cell Carcinoma**
❑ ****Abnormal Glandular Cells (including Atypical, Endocervical adenocarcinoma)**
❑ Other (specify: _____)

HPV High-Risk Results:
❑ Positive
❑ Negative
❑ Test not done
❑ Other (specify: _____)
❑ Unsatisfactory

Plan: ❑ Next routine screening (cytology alone=3 yrs.)(co-testing=5 yrs.)___ ___ / ___ ___ / ___ ___ ___ ___
❑ Short-Term Follow-Up is recommended and will be due ___ ___ / ___ ___ / ___ ___ ___ ___
****Immediate consultation/diagnostic testing required: Diagnostic Provider:** _____

Appointment Date: ___ ___/ ___ ___/ ___ ___ ___ ___

❑ *Request MBCHP Case Management (for assistance in managing patient care)*

MAMMOGRAM RESULTS ❑ Client was "No Show" for Mammogram

Mammography facility: _____

Date of Mammogram**:** ___ ___ / ___ ___/ ___ ___ ___ ___
Please check one: ❑ Routine screening
❑ Short-term follow-up test

Mammogram Type: ❑ Conventional
❑ Digital

BI-RADS Results: ❑ ****BI-RAD 0**
Assessment is incomplete – need additional imaging evaluation OR Film comparison required
❑ BI-RAD 1 Negative
❑ BI-RAD 2 Benign Finding
❑ BI-RAD 3 Probably Benign – initial short interval follow-up suggested
Abnormal result:
❑ ****BI-RAD 4** Suspicious Abnormality - biopsy should be considered
❑ ****BI-RAD 5** Highly Suggestive of Malignancy – appropriate action should be taken

Plan: ❑ Next routine screening due __ __ / __ __ / __ __ __ __
❑ Short-Term Follow-Up is recommended and will be due __ __ / __ __ / __ __ __ __
****Immediate consultation/diagnostic testing required.** **Diagnostic Provider:** _____
Appointment Date: ___ ___/ ___ ___/ ___ ___ ___ ___
❑ *Request MBCHP Case Management (for assistance in managing patient care)*